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WORLD RELIEF CORPORATION (WRC)/ ORGANIZACION PROFESIONAL DE DESRROLLO (OPRODE) EL SALVADOR CHILD SURVIVAL IX PROJECT

San Salvador, El Salvador

MID-TERM EVALUATION

October 25, 1995

Evaluation Team members: Dr. Richard Crespo, Associate Professor
Marshall University School of Medicine
Huntington, West Virginia
(Outside Project Evaluator- Chief of Party)

Muriel Elmer, Ph.D.
Health/Training Specialist
WRC Headquarters

Dr. Luis Palma
Child Survival Program Director

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EXECUTIVE SUMMARY

The World Relief/OPRODE child survival project serves four rural departments in El Salvador, covering a population of 48,078, with a total of 6,469 of children under five and 11,565 mothers. The project will have been operating for 23 months at the end of August 1995. The focus of the project has been on education and community organization. A total of 20 promoters have been trained and 19 are currently active, the number targeted in the DIP. The targeted high risk groups are being reached by the promoters. The extensive home visit schedule of the promoters has built good rapport with families who have children under five. Two hundred sixty six community-based Health Volunteers have been trained and are active; an average of 2 weekly health education sessions are held in every target community; an average of 3.8 days/week are spent in home visits; and monthly community meetings are held in 8 of the 40 target communities. Just under 80% of children are either up-to-date or on schedule with their vaccinations. The project is likely to surpass the stated objective of 80% of children vaccinated. When women were asked about the benefits of the project during the mid-term evaluation, they gave the highest rating to, knowledge of how to prevent illness, vaccinations for their children, and help from the promoters.

An important element of the project design is that implementation is a joint endeavor by WRC and the Salvadorian agency OPRODE. The counterparts are community-based organizations of health committees and local churches. All curative services are provided by the MOH. The project has been effective in mobilizing the promoters to work in the community. Another element of the project design is the phasing of project interventions. Diarrhea management and ARI were emphasized in Year 1 and maternal care and EPI in Year 2. In Year 3 family planning will be added.- These element have been successfully implemented.

The problem areas that will need to be addressed in the second half of the project are in the health information system, the mobilization of Health Volunteers, and community organization for sustainability. The health information system is inadequate and will need to be revised. The project has experienced a delay in training, organizing and mobilizing the volunteers as primary health educators. In the area of community organization, the participation of local churches has been minimal. The project staff must develop a coordinated strategy for developing the capacity of local churches to be involved. The second category of community-based agencies is health committees. Each target community has a committee, however, less than 50% meet once a month and less than 25% have an action plan. The health committees have a greater potential than local churches for operating child survival activities after the project is ended. The project staff should invest heavily in developing the capacity of the committees to continue child survival activities.

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MID-TERM EVALUATION
World Relief/OPRODE
El Salvador
August 20-September 1, 1995

1. Accomplishments

The project will have been operating for 23 months at the end of August 1995. It is functioning in 40 communities, an increase of 2 from Year 1. The focus of the project has been on education and community organization. No supplies have been provided, all curative care is provided by the local Ministry of Health posts called, *Unidad Sanitaria.* A total of 20 promoters have been trained and 19 are currently active, the number targeted in the DIP. One promoter resigned in October of 1994 and was replaced in January 1995. A total of 16 training events have been held for promoters. The supervisors have participated in all 16 and had 3 additional training events for a total of 19. The Project Coordinator participated in 7 training events, including training by Johns Hopkins in KPC survey methodology in Mexico and in Guatemala. Refer to Appendix A for a complete listing of all training activities. As a result, 266 Health Volunteers have been trained and are active; an average of 2 weekly health education sessions are held in every target community; an average of 3.8 days/week are spent in home visits; and monthly community meetings are held in 8 of the 40 target communities. Additionally, promoters consistently collaborate with the local *Unidad Sanitaria,* including in the recent outbreak of dengue fever and 2 of the promoters have been teaching health classes in the local school.

2. Effectiveness

The only reliable data regarding outcomes are in reference to childhood vaccinations. Monthly promoter reports indicate that already just under 80% of children are either up-to-date or on schedule with their vaccinations. The project is likely to surpass the stated objective of 80% of children vaccinated. Data gathered during the mid-term evaluation showed that 75% of women interviewed were able to identify at least one sign of ARI. Additionally when women were asked about the benefits of the project during the mid-term evaluation, they gave the highest rating to, knowledge of how to prevent illness, vaccinations for their children, and help from the promoters.

Unfortunately, the sentinel-site data gathering system used to monitor progress towards the rest of the project's objectives yields unreliable and invalid data. For example, the data in the second year, third quarter report indicate that 52% of mothers exclusively breastfeed. The promoters report from their observation that the number is much lower. Experience in child survival also indicates that this figure is unrealistic. Additionally, data from the second to third quarter report show increases in coverage in certain objectives of 12%, 18% and

26%. Such increases in one quarter are highly unlikely. The system will need to be revised and a new system put in place. (Refer to recommendation III. page 1 1 .)

Lesson Learned: The data gathering system for monitoring progress toward project objectives needs to be based on a random collection system that represents the whole target population just as the baseline and final survey are. This is the only way to accurately monitor progress towards project objectives. The evaluator recommends that the project staff use a rapid, random data gathering system to gather data on key indicators.

The targeted high risk groups are being reached by the promoters. A high percentage of their time is spent in systematic home visits They are to be commended for their diligence. What is not known with certainty is the impact of their intensive home visiting, as referred to in the above paragraph.

3. Relevance to Development

The extensive home visit schedule of the promoters has built good rapport with families who have children under five. They have worked with mothers one on one in teaching and helping mothers with referrals. In all of the communities visited in the mid-term evaluation mothers felt that they are treated much better at the *Unidad Sanitaria* than before and are more likely to take a sick child to the physician. In the four *Unidades Sanitarias* visited by the evaluation team, the promoters were highly regarded and considered a valuable member of the health team. This has facilitated better access to government health services. Each of the promoters have also been active in arranging for the MOH to conduct vaccination campaigns in communities where the coverage had been inconsistent. They have also been active in water and sanitation projects and recently in education about dengue fever. Additionally, promoters were very active in support of the MOH in an outbreak of cholera earlier in the year.

4. Design and Implementation

The total population served by the project is 48,078, with a total of 6,469 of children under five and 11,565 mothers. These figures compare favorable with the targets in the DIP, except in the projections for children. The projections in the DIP were: 51,917 (total population), 12,616 (children) and 10,838 (mothers). The target population for the project changed from the writing of the proposal to the writing of the DIP. Project staff encountered difficulty in obtaining census data because of the uncertain environment right after the end of the civil war and changes in target communities recommended by the MOH. These changes were discussed with and approved by Jamie Henriquez, USAID Project Officer. In final analysis the number of people actually served compares favorably with the projections in the DIP.

An important element of the project design is that implementation is a joint project by WRC and the Salvadorian agency OPRODE. The counterparts are community-based organizations of health committees and local churches. All curative services are provided by the MOH. The project has been effective in mobilizing the promoters to work in the community.

Another element of the project design is the phasing of project interventions. Diarrhea management and ARI were emphasized in Year 1 and maternal care and EPI in Year 2. In Year 3 family planning will be added. This element has been successfully implemented. The promoters and volunteers were not pressured to learn and apply a large number of interventions all at once and the promoters believe that mothers were not overwhelmed with information. The major limitation of this element as reported by the promoters is that they have not been able to be as responsive to perceived needs of mothers. The promoters, however, did adapt their strategy when epidemics of cholera and dengue fever occurred. Another limitation is that family planning is an important, yet complex intervention and the project will have only one year to focus on this area.

Lesson Learned: Phasing interventions can be an effective way to simplify a package of interventions and allows project staff to concentrate on a few things well. This strategy is especially effective where baseline data on certain objectives are especially low.

4.2 Management and Use of Data

As mentioned in Section 2, page 1, the sentinel system created to monitor project outcomes is invalid. The project also has a health information system that gathers detailed data on each of the project's objectives. The data gathering system begins with promoters keeping record of illness and learned health behaviors during their home visits. These records are given to supervisors on a weekly basis. The supervisors have found these data useful in their weekly planning meetings with their promoters. Promoters' performance is evaluated and the data are used to guide planning for the coming week.

The supervisors compile the weekly data into a composite monthly summary of the data from all their promoters. The project coordinator then compiles the monthly summaries into a quarterly report for the whole project. Ideally the monthly summaries are to be used in the monthly planning meeting with the Project Coordinator and Supervisors. In reality, however, the data reported in the monthly summaries is too detailed, is not directly related to project goals and there is no way to use some of the data. Consequently it has not proven to be useful. For example? the monthly summaries reports the total number of children with diarrhea. Yet there is no way to use this information to compare with previous

reports or previous years because this number has no denominator and does not relate to any project objective.

Lesson Learned: The Health information system needs to be greatly simplified and should focus on data related to project objectives. It is often tempting to gather large quantities of data in order to take advantage of the opportunity. In Child Survival projects, however, it is better to have fewer data that are useful rather than large quantities that clog up the system. (Refer to the Recommendations section page 1 1, number III. for specific recommendations for change.)

4.3 Community Education and Social Promotion

The project's interventions are exclusively educational, no service provision is made. While the promoters have conducted extensive health education, the project design calls for the volunteers to take the lead, with the promoters focusing on training and community organization. The project has experienced a delay in training, organizing and mobilizing the volunteers as primary health educators. Families were to have been assigned to volunteers by the end of Year 1. Eleven months into the second year, 34% of the volunteers still did not have assigned families. The volunteers have only begun to facilitate health education sessions with mothers in the ninth month of Year 2. This delay could affect the sustainability objectives of the project since they have only 15 months to build relationships and establish their credibility.

4.4 Human Resources for Child Survival

The OPRODE staff involved in Child Survival interventions are: 1 Project Coordinator, 1 Health Educator, 3 Supervisors and 19 Health Promoters. On the part of the communities, 266 Health Volunteers are currently active. (Refer to Appendix B for listing of the number of Volunteers per community.) The DIP projected that each promoter would train and supervise 10 volunteers. The fact that some Promoters have more than 10 does not appear to affect the quality of their work. The Volunteers work as teams which facilitates the Promoters' training supervision. It also make the Volunteers more effective. The Volunteers spend an average of 1.8 days in home visits and assist the Promoters with an average of 2 health meetings a week with mothers. In the second year the Volunteers have received an average of 1.7 training session a week.

The Volunteers interviewed for this evaluation who have families assigned are all regularly visiting their families. Most of them are able to visit all of their families in a period of 2 to 3 weeks, thus there is consistent and sufficient interaction with each mother in these communities. If the Volunteers are able to

continue at this pace, then they will have develop good rapport and enhanced their credibility.

The role of the volunteers is to serve as the front line educators in the project. The project staff have been slow to mobilize them for this role. Given that the funding of the project is for three years, the volunteers ideally should have been leading community education by the end of the second year. The late start will make it that much more difficult for them to grow into leadership position in their communities. It will be critical that the volunteers continue with their pace of home visits and health education meetings referred to in the previous paragraph to make up for this delay.

Promoters and Volunteers have received substantial training. (Refer to Appendix B for a Training Program Summary.) The strategy of phasing in child survival interventions has made the training program more effective, so that learners do not have to deal with a large volume of content all a once. The area in which the Supervisors, Promoters and Volunteers have had the most difficulty is in Health Education.

In November 1994 they participated in a workshop on Popular Education. The strategy for follow up was not implemented by the project staff, thus when the WRC Child Survival Director visited the project in early February 1995 she arranged for further training. In February and March 1995 a World Relief consultant came from Honduras to train the promoters and volunteers in participatory educational techniques. The consultant conducted extensive on-the-job training in learning games, drama, group discussion techniques, etc. She also helped to identify and train a health educator for the project. The results of this training were clearly evident during the mid-term evaluation. In all of the training sessions observed by the evaluation team these participatory techniques were used. The consultant also helped the promoters develop a set of basic health messages for each of the project's objectives. (Refer to Appendix C.)

The limitation of this training, however, is that it focuses on information transfer, it does not use participatory techniques to enhance mothers' problem-solving and solution-posing skills. The impact of the information transfer orientation is less likely to be transferable to other health problems and will drop off over time. The power of Popular Education is in stimulating critical thinking and decision-making which ideally results in independent thinkers. The evidence of the effectiveness of this approach to learning is that it was considered a threat in most right-wing dictatorships in Latin American. Now that there is freedom in El Salvador, it is unfortunate that project staff did not make full use of the popular education approach.

4.5 Supplies and Materials for Local Staff

This project does not supply materials and equipment for Child Survival interventions. The source of supply is the MOH. The key items supplied by the Ministry are oral rehydration packets, antibiotics for ARI and family planning resources. Oral rehydration packets are generally available. The Promoters and Volunteers have also been diligently teaching mothers how to mix home solutions. They report having conducted demonstrations in each mother's home during routine home visits.

The supply of antibiotics at the *Unidad Sanitaria* is inconsistent. In one of the four units visited there were none. In another they were down to a 3-day supply. The availability appears to go in cycles that are affected by end of fiscal year budget shortfalls and local epidemics, such as cholera and dengue fever.

In the area of family planning, the *Unidad Sanitaria* had sufficient supply of oral contraceptives. The supply of injectable contraceptives is inconsistent.

4.6 Quality

The project staff do not have a way to asses the level of knowledge and skills of mother and to monitor progress towards the project's objectives. While it appears that Promoters have developed good relationships in their communities, they do not know what change has happened in the health of mothers and children. (Refer to Section 4.2, page 6, for further details and Section 6, page 1 1 for recommendations.)

4.7 Supervision and Monitoring

The Project Coordinator meets with the three Supervisors and the Health Educator once a month for a half-day planning meeting. Additionally, the Supervisors work in the OPRODE office one day a week, where the Project Coordinator meets with them individually or as a group. The Supervisors have a weekly planning meeting in the field with the Promoters. They also spend three days a week working with the Promoters on the job. Two supervisors have six Promoters and one has seven.

The Supervisors provided on-the-job feedback to the Promoters. The health education consultant created a check list for the Supervisors to evaluate the content of the Promoters health talks. The checklist, however, proved to be a superficial tool since the Promoters knew the subject matter. Additionally, the tool pressured the Promoters to present content regardless of mothers' learning needs. Consequently after a month of using the tool the Supervisors justifiably discarded the check list.

A more useful supervisory tool has been the Promoters weekly summary of activities. They record number of homes visited, health talks given, volunteer training, community meetings, etc. The Supervisors review these reports with the Promoters in their weekly planning meetings. It has proven to be an effective tool in motivating the Promoters as they see where they stand in relation to their peers.

With the extent of time that the Supervisors spend in the field, they appear to have a good understanding of the Promoters' performance. They have been effective in supervising the technical and content aspects of the Promoters responsibilities.

The one area where they have not been able to train Promoters in the full extent of their job is health education. The project has had a position for a Health Educator, but it has been difficult to fill this position. The original educator moved to a supervisors' position when one of the original supervisors left and the position was vacant for seven months. Additionally, although the original educator was a school teacher, she did not have experience in adult education. A new educator was hired in March 1995. The new educator has extensive experience in adult education. Unfortunately this position was not filled by someone with the right experience until the mid-term of the project. The project has been negatively affected by the lack of effective leadership in this area.

<u>Lessons Learned</u>: A project that concentrates its interventions in health education must have someone with experience and skills in adult education on the team. For this type of project, filling this position should be a top priority. An argument could be made that implementation should not begin until this position is filled.

The Project Coordinator should deliberately monitor the progress of components of the project that have been behind schedule. It is normal for some components to be behind schedule, however, the number of components behind schedule is a disturbing trend. The following outline lists the activities by targeted date and actual completing date.

- **A. Assigning families to volunteers: planned -- end of year 1. Actual: 66% assigned by last month of year 2.**
- **B. Promoters using Popular Education strategies: workshop in November 1994. No follow-up of workshop. Games, diagrams, etc are being used, but only for information transfer, not problem-solving.**
- **C. Promoters working through health volunteers, with volunteers educating the community by the end of Year 1. This is only beginning to happen at the end of Year 2.**
- **D. Volunteers trained in health education by the end of Year 1. Actual: training competed after mid-term of the project. This delay is critical**

since the project is focused on education and has no service delivery components.

E. Fifty percent of Health Committees with an action plan by the second year. Actual: less that 10% have one by the end of Year 2.

F. Coordination with local churches: 14 local churches actively supporting health activities in Year 2. Actual: no church is actively supporting health volunteers. Coordination with local churches is primarily focused on monthly information meetings with local pastors. Past the mid-term of the project the Project Coordinator is still having to explain the role of volunteers and promoters to local pastors.

G. Use of risk maps: an up-dated risk map for each community in Year 1. Actual: Risk maps were completed after the end of Year 1. Sixty four percent were last revised five months ago. Normally, risk maps should have been developed as part of the census taking done in Year 1, and then updated at least on a quarterly basis.

H. Traditional Birth Attendants: one trained in each community by the end of Year 1. Actual: less than 50% of communities have a TBA by the end of Year 2.

4.8 Regional and Headquarters Support

The WRC Child Survival Director has visited the project once a year, according to plan. WRC sent a staff member to assist in the baseline survey design and implementation. Additionally, WRC sent an education consultant for two months at their expense in order to strengthen this component. The Child Survival Director has been in regular correspondence with OPRODE staff. OPRODE has a bilingual secretary, thus all communication is translated into Spanish.

The principle constraint on the part of WRC is the lack of staff with Spanish language ability. Staff are not able to contribute to the full extent of their ability and the communication process is slowed by the need to translate. WRC is in the process of hiring a staff member who is technically competent and fluent in Spanish to assist the Child Survival Director at WRC headquarters.

The project has faced financial pressures due to severe inflation. Consequently WRC has assisted OPRODE will additional funding to compensate for shortfalls due to inflation.

4.9 Assessment of Counterpart Relationships

The project is being implemented by WRC/OPRODE, and the counterpart agencies are-local churches and health committees. The participation of local churches has been minimal. A few churches have participated in isolated events, but there has been no sustained participation by local churches that would give

evidence of sustainability. Part of the problem is that some of the target communities changed from the time of the proposal to the writing of the DIP. The change was requested by the MOH, because their coverage expanded during this time and they requested that WRC/OPRODE work in underserved communities. The churches in some of the communities that were omitted were among the strongest supporters of the promoters.

Nevertheless, local churches continue to be a key community-based counterpart organization in the project's plans. The Project Coordinator has been holding monthly meetings with some local pastors, but there has been no follow-up by supervisors and promoters. The project staff must develop a coordinated strategy for developing the capacity of local churches to be involved. The first step is for the Project Coordinator to concretely define the role of local churches as counterpart agencies and articulate criteria for their involvement. This will give project staff a sense of direction for working with local churches.

The second category of counterpart agencies are the community-based health committees. Each target community had a committee by the end of Year 1, as intended in the DIP, however less than 50% meet once a month and less than 25% have an action plan, as projected by the DIP. The health committees have a wide range of organization and experience. At the high end of the scale, one committee is in the process of organizing a local pharmacy for the purpose of meeting an important need and generating a small income to sustain their health education programs. Another committee has organized a series of health fairs and raffles in order to enhance their visibility and generate income. Promoters reported that three other committees has similar levels of activity. At the low end of the scale are committees that meet less than once a month and have no plans of their own. At least 60% of the health committees show little evidence of sustained initiatives.

The health committees have a greater potential than local churches for operating child survival activities after the project is ended. The project staff should invest heavily in developing the capacity of the committees to continue child survival activities.

4.11 Referral Relationships

Medical referrals are provided by MOH outpatient clinics called *Unidades Sanitarias.* In the four visited by the evaluation team there were good working relationships with the promoters. In every case there had been active collaboration in areas such as vaccination campaigns, cholera and dengue fever control, water and sanitation projects, etc. Promoters send monthly reports to the local *Unidad Sanitaria.* The reports have been highly appreciated. In community interviews, mothers reported that they have received better care at the *Unidad Sanitaria* since

the project began. The promoters are highly appreciated because they provide education and promotion coverage in areas that the MOH cannot reach.

The referral/counter-referral system appears to be working well. Promoters regularly make referral as a result of their home visits. The MOH staff respect the referrals and they generally send instructions back to the promoter in writing. The only problem is that patients sometimes lose the notes from the doctor.

4.13 PVO Networking

OPRODE is a member of the PROSAMI consortium of PVO's, and the project's Coordinator has had a leadership position in PROSAMI. OPRODE has networked with Salvadorian PVO's for some of the training in Child Survival interventions.

In the field, the promoters have drawn on the resources of Profamilia, a family planning agency. Promoters have coordinated the supply of contraceptives and made referrals. Profamilia has provided valuable assistance, unfortunately its funding has been reduced and many of its field staff are no longer in place.

The one area in which there has been potential for duplication is where the MOH has assigned a promoter to the same area where an OPRODE promoter is working. Fortunately, the evaluation team saw no duplication or competition. The promoters have all devised working agreements and divided up responsibilities. The most common arrangement is for them to divide the area and each cover half of the district. The OPRODE promoters in some instances have supported the MOH promoters with educational materials and have facilitated access to supplies.

4.13 Budget Management

The rate of expenditures compared to the budget is on target. OPRODE has a good financial management system. As referred to previously, costs have risen above original projections because of inflation. OPRODE staff worked hard at cutting costs, and with some financial assistance from WRC has managed the situation well.

Currently inflationary pressures have been slightly reduced and it appears that OPRODE can finish the project within its budget. It is not likely that the budget will be underspent. (Refer to the Pipeline Analysis in Appendix D.)

5. Sustainability

The sustainability strategy has three components: trained volunteers, community health committees and local churches. In reality, the trained volunteers

and health committees are one in the same. The status of these components has been described in Section 4.3, page 4, and Section 4.9, page 8, regarding the volunteers. The table in Appendix A, provides a summary of the status of this component.

Implementation of the sustainability strategy is behind schedule. The process of training volunteers, assigning families and giving them independent responsibilities has been poorly managed. Twenty three months into a three year project is too late to have 34% of volunteers without assigned families. It is much too late in the life of the project for only eight out of 19 volunteer teams to function independently. Part of the problem may be that the sustainability goals and objectives can be interpreted in different ways, however, managing the process is not only a matter of adherence to minimum standards set forth in the sustainability objectives. This component must be guided by sound management principles, given that sustainability is a critical component of the project plan. Project staff must produce more than the minimum of the sustainability plan for it to be successful.

Project staff must work towards creating substantive participation on the part of local church and health committees. It is imperative that project staff concentrate on this component, otherwise the sustainability component is in jeopardy.

6. <u>Recommendations</u>

I.. The Project Coordinator should deliberately monitor the progress of components of the project that have been behind schedule. It is normal for some components to be behind schedule, however, the number of components behind schedule is a disturbing trend.

II.. The Project Coordinator should develop an implementation plan that guides project staff in the critical areas that need developing and monitoring for successful completion of the project. The plan should be used by the Project Coordinator and the Supervisors in their monthly planning meetings and by Supervisors and Promoters in their weekly planning meetings. The implementation plan should include a time line for monitoring progress in each of the critical areas listed in #1, above.

III.. The Project Coordinator should implement a data gathering system to replace the sentinel system now in place, in order to monitor progress towards meeting the project's objectives. The system could have two sources of data. One source could be the Volunteers' family registry. It could provide data on vaccinations, ARI referrals, prenatal care and maternal TT immunizations. The Volunteers should gather these data on a weekly

basis in the registry recommended in VI, below. The other source could be a system of rapid random assessments of the remaining objectives, one per month, The rapid assessment would only take one day a month if done by the promoters. It is imperative that a system be in place immediately, since there is currently no way to know the progress towards the project's objectives, except childhood immunizations.

IV.. Promoters should no longer conduct health education in the community, all education should be done by the volunteers. While the promoters have been diligent in health education and for the most part have a good relationship with the community, the change agent in the community should be the volunteers. It is imperative that volunteers take the leadership now if they are to function after the project ends.

V.. Supervisors should introduce the Volunteer to the *Unidad Sanitaria* immediately and the supervisors and promoters should have a strategy for building the relationship between the MOH and volunteers.

VI.. Volunteers should each have a register of their families, and keep it up-dated on a weekly basis. The register should be in a binder or some kind of special notebook so as to communicate the value of the register. It should contain at least a list of all family members, children at risk, vaccinations and pregnant women.

VII. The Project Coordinator and Supervisors should be sure that promoters and volunteers do not use the term bronchitis for pneumonia. During the site visits, volunteers and even a few promoters, used the terms interchangeably. The lack of differentiation could lead to mothers associating a cough with pneumonia.

VIII The Project Coordinator and Supervisors should design a more expansive package of incentives for the volunteers. At present the budget item for incentives is primarily being used to pay for refreshments at health education sessions. The incentives should focus on things that enhance self-confidence and leadership skills, rather than material items such as t-shirts. For example, arrange for exchange visits among volunteers so that they can see how others are doing things. Another example is to promote the development puppets, drama groups, etc. through financing background sets and locally appropriate equipment.

IX.. The Health Educator and Supervisors should develop a plan for educating volunteers in the use of popular education for critical analysis and problem-solving. The plan should be developed immediately and should focus the training at the local level. Supervisors and promoters should be the primary

trainers. New educational materials need to be designed for this purpose. At the present, nearly all educational material is designed only for information transfer. A few of the promoters (e.g. Jose and Gabriel) have developed their own materials. Jose has developed a drama team. The Health Educator should duplicate and share these materials and examples with the others.

X.. The Health Educator should systematically visit each Department team (Sonsonate/La Libertad, La Paz, Usulutan) and do on-the-job training in popular education. She should not wait to be invited.

XI.. Every Health Committee should have a sustainability project. Promoters should make it priority to help the committees do so. A few committees have initiated their own projects. For example, one committee is planning to open a community pharmacy. Another has organized health fairs. Having such projects is crucial for the sustainability of the health committees.

XII.. The Project Coordinator, supervisors and promoters should have a coordinated plan for developing the capability of local churches.to participate in the project. Up to this point churches have had minimal participation, yet they are part of the sustainability strategy of the project. The Project Coordinator has been meeting with local pastors, but there is no follow-up. The supervisors and promoters should follow-up these meetings with the intent of helping churches develop health promotion activities.

XIII. The Project Coordinator should concretely define the role of the church in sustainability. This lack of definition weakens the projects sustainability strategy.

XIV.. Promoters should nurture a relationship between volunteers and church leaders so that these two components of the sustainability plan work in concert. A relationship between the two is a critical factor in sustainability for this project.

xv. The Project Coordinator should develop a system for maximizing the use of the project vehicles. There are two vehicles, yet the supervisors and health educator take the bus and walk wherever they go because they cannot drive. The budget is tight because of inflation, yet it may be possible to hire a driver one or two days a week. This could be a big boost in efficiency for the field staff.

XVI.. The Project team should modify three of their objectives.

A. The objective for identifying risk factors for ARI should be reduced from mothers identifying two signs to identifying one sign. That sign

should be rapid breathing. This will simplify the educational task and at the same time focus on the most critical sign.

B. The objective for exclusive breastfeeding in the first four months should be reduced from 40% to 20%. The objective of 40% represents a strong desire on the part of the team to address the issue, however, experience indicates that it is unrealistically high. Twenty percent represents a 9% increase from the baseline of 11%.

C. The objective for families using birth control should be decreased from 50% to 40%. According to the project design, family planning is not going to be addressed until the third year. Thus the three year objective for family planning is in fact a one year objective. The baseline is 35%.

7. Summarv

Evaluation Team: Richard Crespo, Ph.D. (independent evaluator), Muriel Elmer, Ph.D. (WRC), Luis Palma, MD, MPH, Dolores Luna, Gloria Quinteros, Berta Aguilar, Anabel Quinteros (OPRODE).

Time spent: 1 1 days in the field.

Field visits: The team visited 15 of the 40 communities

Methods: Crespo and Elmer interviewed the OPRODE Executive Director, Ana Cecilia Melendez, MD, the Project Coordinator, Luis Palma, MD, MPH, the Health Educator, Anabel Quinteros. They conducted a two and a half hour group interview with the Supervisors. Crespo led a four hour group interview session with 18 of the 19 promoters.

The whole evaluation team conducted group interviews with mothers in their communities. They used the nominal group technique to identify benefits and obstacles to participation. The mothers were also asked to identify three signs of ARI and to rank order the level of responsibility for child health of parent, nurse and physician.

Crespo and Elmer observed six health education sessions for mothers led by volunteers.

Crespo led a six hour session with all the project staff to review preliminary findings and create an action plan based on the findings.

Crespo led a four hour review and planning meeting with the OPRODE Executive Director and Project Coordinator, based on a list of preliminary recommendations.

APPENDIX A

COMMUNITY PROMOTION ACTIVITIES

COMMUNITY PROMOTION ACTIVITIES
as Reported by the Promoters
World Relief/OPRODE Child Survival Project
El Salvador

Summary:
Total number of active volunteers as of August, 1995 = 284 (68%)

Total number of active volunteers assigned to their families = 192

Volunteers received their family assignments between 2/95 and 7/95

First Risk Maps created 12/94. Last revision = between 3/95 and 5/95

C'ommunity	Active Volunteers	Volunteers with Families Assigned	Date Last Families were Assigned	Risk Maps	
				First Created	**Last Revision**
La Paz					
San Antonio Abajo	10	9	4/95	12/94	3/95
Maquilishuat	7	5	4/95	12/94	3/95
Chaperno	***14***	10	3/95	12/94	3/95
San José Carrizal	12	11	3/95	12/94	3/95
Tierra Colorada	12	***12***	2/95	12/94	3/95
Las Delicias	***9***	5	5/95	12194	3/95
Las Piedronas	***7***	***7***	5/95	1/95	3/95
Los Zacatillos	15	14	5/95	1/95	3/95
Jalponga	16	***8***	2/95	12194	3/95
Longaniza	12	***2***	2/95	12194	3/95

Community	Active Volunteers	Volunteers with Families Assigned	Date Last Families were Assigned	Risk Maps	
				First Created	**Last Revision**
Santa Cruz Loma	8	8	3/95	12194	3/95
Colonia **Santa** Inés	**6**	**6**	3/95	12/94	3/95
El Modelo	5	5	7/95	12194	3/95
Tilapa Abaj o	11	11	3/95	12/94	3/95
Usulután					
El Cocalito	1	0		12/94	5/95
Jardínes #1	0	0		12/94	5/95
Jardínes #2	4	0		12/94	5/95
El Amate	0	0		12/94	5/95
DEUCSEN	0	0		12/94	5/95
El Cocal	9	0		12/94	5/95
El Mirador	2	0		12/94	5/95
Cantón El Trillo	6	0		12/94	5/95
Colonia El Milagro	12	12	7/95	12/94	5/95
Paraíso #1	4	0		12/94	5/95
Paraíso #2	5	3	7/95	12/94	5/95
La Campiña	3	0		12/94	5/95
Puerta El Sol	11	11	7/95	12/94	5/95
La Chentia	0	0		12/94	5/95
La Libertad					
Colonia Montemar	10	10	7/95	12/94	3/95

Community	Active Volunteers	Volunteers with Families Assigned	Date Last Families were Assigned	Risk Maps	
				First Created	**Last Revision**
Matazano	12	***5***	4/95	***12194***	3/95
Conacastes	10	5	3/95	12/94	3/95
La Esperanza	***8***	***4***	3/95	12/94	3/95
Las Mercedes	***4***	***4***	3/95	12/94	3/95
Peña Partida	***3***	***3***	7/95	12/94	3/95
El Jute	***4***	***4***	7/95	12/94	3/95
Gallo Solo	***4***	***4***	7/95	12/94	3/95
Cuesta El Toro	***2***	***2***	7/95	12/94	3/95
Sonsonate					
Las Lajas	***6***	***6***	7/95	***12194***	3/95
Ceiba de1 Charco	***3***	***2***	7/95	12194	3/95
Chorro Abaj o	***6***	***2***	***71195***	12/94	3/95
Cuntán	1 Community not assigned until 5/95	0		6/95	
Las Mariás	10	***2***	7/95	12/94	3/95

APPENDIX B

CHILD SURVIVAL TRAINING PROGRAM SUMMARY

Child Survival Training Program Summary
World Relief/OPRODE Child Survival Project
El Salvador
as of **August, 1995**

Type/# Dates	Training Topics	Topic Hours	Training Methods For Topic
Volunteers (372) Oct. - Dec. '94 Volunteers (349) Jan. - Ap. '94	CDD & ARI EPI MH (includes FP)	30 20 40	Pictures, slides, video, lecture, discussion, group activites, demonstrations
Project Coordinator (1) August, '93	Training by JHU in the 30 cluster KPC survey methodology (in Mexico)	30	Lecture, discussions, field work
Project Coordinator (1) Aug., '93, Dec. '94	Further training in implementing a 30 cluster KPC survey in Honduras and Guatemala	20	Field work
OPRODE Director (1) Project Coordinator (1) Health Educator (1) Supervisors (3) Administrator (1) Nov. 8, '93	Quarterly action and reporting plan	8	Lecture, discussion
Promoters (19) Supervisors (2) Nov. 21,'93 - Mar. 7, '94	Basic Training Course (MSPAS approved) Education, prevention, care and referral of cases of diarrhea and ARI, education, detection, and referral of pregnant women; education and care of the mother and the newborn; promotion and assistance with FP; promotion of growth and development; promotion and delivery of immunizations and promotion of basic health activities.	180	Lectures, group discussions, flipcharts, slides, videos, field visits to health centers and communities, practicum in a health center for 2 weeks.

Type/# Dates	Training Topics	Topic Hours	Training Methods for Topic
Promoters (19) Supervisors (3) Others (11) Jan. 15-30 '94	Implementing a baseline KPC 30 cluster survey	24	Presentations, discussions, roleplays, data gathering and analysis of results
Director of OPRODE (1) Project Coordinator (1) Supervisors (3) Administrator (1) March 22, '94	ARI - related to the adult learning process, use of story telling to communicate ARI messages and the clarification of one AR1 health message	4	Lecturette, story telling, roleplay of the story, discussion
Director, OPRODE (1) Project Coordinator (1) May 24, '94	Planning and Evaluation of goals and objectives	6	Lecture, group discussion
Promoters (19) Supervisors (3) Ap. 5&6, '94	CDD	12	lecture, group discussion, slides, videos, demonstration.
Promoters (19) Supervisors (3) May 10-I 1, '94	First Aid	8	Lecture, group discussion, demonstrations and return demonstrations
Promoters (19) Supervisors (3) Jun. 13-17, '94	Evaluating educational materials	8	Flipcharts, observation and analysis of educational materials
Promoters (19) Supervisors (3) Jun. 17, '94	Breastfeeding	8	Lectures, videos, group discussion, demonstration
Promoters (19) Supervisors (3) July 28&29, '94	Introduction to the HIS	6	Presentation of the forms, analysis of forms, practice using forms.
Promoters (19) Supervisors (3) Sept. 6-7, '94	ARI	12	Lecture, working with manuals, analysing posters, group discussions.

Type/# Dates	Training Topics	Topic Hours	Training Methods for Topic
Supervisors (3) Oct. 19-21, '94	CDD, ARI, EPI	18	Lectures, group discussion, demonstrations
Promoters (19) Supervisors (3) Oct. 27&28, '94	Nutrition	12	Lectures, group discussions, slides, flipcharts, demonstrations
Project Coordinator (1) Health Educator (1) Supervisors (3) Promoters (19) Nov. 16-20, '94	Common teaching problems faced by promoters Health for the whole person and implications for health education content Facilitating critical analysis of health problems among community members	40	Discussions, small groups, analysis using codes that represent underlying health problems, designing their own codes to stimulate dialogue, practice in their communities
Promoters (19) Supervisors (3) Jan. 17&18, '95	Community Participation	12	Lecture, group discussion, analysis of material
Promoters (19) Supervisors (3) Feb. 9&10, '95 Feb. 15-17, '95 Mar. 7-9, '95	Popular Education	70	Lecture, games, group discussion, nominal group techniques, flipcharts, discussion of posters, practice sharing health messages
Project Coordinator (1) Ap. 5, '95	Sustainability	6	Lectures, presentations, discussion
Promoters (19) Supervisors (3) May 2-3, '95	Planning Program Activities	12	Lectures, group discussion, demonstration of action plan, practice creating a Plan
Promoters (19) Supervisors (3) July 13&14,'95	Community Participation	6	Lectures, group discussion, listed the functions of the community health committee